espanola
regional hospital and health centre
hôpital régional et centre de santé
d'espanola

COVID-19 TESTING FOR TRAVEL

Things to consider:

1. There is a COVID-19 testing window, which is the number of hours in which a negative test result is accepted by your destination.
2. Your test must be scheduled (Monday to Thursday) with the Covid Assessment Centre and paid in full for ahead of time. 705-869-1420 ext. 4500. http://espanola.caredovesite.com/on-site-covid-testing-for-international-travel
3. A prepaid fee of $205.00 is required on testing day.
4. Your results will not be available until the following day.

Disclaimer:

As the COVID-19 pandemic evolves, the test standards and requirements continue to evolve. The Espanola Regional Hospital and Health Centre (ERHHC) will work to maintain testing which meets these evolving standards. However, it is not possible to predict every change which might occur, or the timing of any change. ERHHC is not responsible for any unforeseen circumstances where the provided testing does not suffice the travel carrier. We have followed the directions of the U.S. Department of State and the CDC, regarding travel to the United States; however, we are not liable for any unforeseen loss or additional costs or testing required. Health care providers and their patients should recognize that this risk is outside of our control.

*** Please remember given the amount of uncertainty with these tests, it does not change our recommendations or management: still physically/socially isolate, practice respiratory etiquette, stay six feet apart from others, wear a mask, and wash your hands thoroughly.**

CONSENT

Through your signature below, you are aware of the risks and you have taken the opportunity to ask questions about the test. If you undergo testing, you acknowledge that you did so voluntarily.

I also understand that my records will be protected under PHIPA, are confidential, will only be released to myself, and cannot be disclosed without my written consent.

I hereby declare that I understand and acknowledge all of the consequences that may arise from knowing my status if I am tested positive for COVID-19 and will follow the guidance of the Public Health Authority.

I agree that this is a paid service and will provide payment prior to any testing.

I hereby give my permission/consent to have a COVID-19 screening test collected and then receipt of a paper copy of my results the following day, upon showing my personal identification.

Date: _____

Signed by: _____ Printed name: _____

Date of COVID-19 test: _____